The politics of evidence: 'Doing nothing' about LGBT health inequities by the WHO

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The politics of evidence: 'Doing nothing' about LGBT health inequities by the WHO

*In this post **Dr Po-Han Lee (http://www.sussex.ac.uk/profiles/336792)** (Doctoral Tutor in Sociology and Law at the University of Sussex) summarises key findings from his recently completed PhD in Sociology (http://sro.sussex.ac.uk/id/eprint/88275/), which examines international inaction in the face of the health disparities of sexual and gender minorities.*

How is 'nothing' produced and justified, and how is it functioning? Here, I will take a multilateral debate in the World Health Organisation (WHO) over the issues regarding health inequities experienced by sexual and gender minorities (SGMs) as an example.[1]

On request by the US and Thailand, the WHO Secretariat produced a report on LGBT health in May 2013 for the Executive Board (EB) – the organ authorised by the WHO Constitution to adopt policy agenda for the WHO governing bodies especially the annual World Health Assemblies. That was the very first time that the LGBT health issue had been put on the table in the WHO governing body. The debate was an intense one, lasting more than six hours, and in the end, the agenda item was removed from the final agenda, and kept only as a footnote. In May 2015, the footnote was deleted for good, and after that, an interstate informal consultation was pursued by Colombia.[2] However, the working group failed to achieve any consensus either. Since then, the topic has never been brought up again.

Geographically, the WHO divides the world into six regions – each has its own governing body and a committee with regard to health affairs on the regional level. The degree of development of LGBT health issues varies across different regions. The Pan American Health Organisation is the most active one; it has recognised sexual orientation as a social determinant of health (Res. CD50.R8). It adopted another resolution (CD52.R6) addressing the causes of LGBT health disparities in October 2013 after the discussion in the EB was suspended. In the Regional Committee for Europe, it was discussed in the context of the *Health 2020* (http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being) policy framework. LGBT populations are referenced only in relation to HIV/AIDS response and prevention by the Regional Committees for the Western Pacific and for South-East Asia. In the Regional Committees for the Eastern Mediterranean and for Africa, nothing is mentioned at all.

At the debate between members of the Executive Board in 2013, the reasons for removing the agenda item included:

1. a *lack of capacity* for the WHO to address politically sensitive human rights issues, which had been addressed by the UN human rights bodies;
2. a *lack of consensus* between states on what health issues should be prioritised;
3. a *lack of a universally agreed definition* of affected communities, 'LGBT people' in this case; and,
4. a *lack of evidence* regarding the existence of the health inequities in question.

In those meetings, member states employed many human rights notions, but eventually they decided that the WHO should step away from *other* human rights concerns (https://blogs.shu.edu/ghg/2018/03/15/the-demagogies-of-lack-the-whos-ambivalence-to-the-right-to-health-of-lgbt-people/), as if the right-to-health issues could be addressed in isolation. This suggests that these states were not committed to the so-called human rights-based approach to global health governance, although they had spoken a great deal in the language of human rights.

Can no-evidence say anything?

The WHO member states involved in the debate in the end made an unusual decision, which was to 'do nothing' about the health disparities experienced by SGMs. That decision is particularly relevant to the power of official and expert discourses regarding knowledge production in health research. That is, the inaction was taken and justified based on the fact that the epidemiological science had not proven the existence of SGM health inequities yet.

Among those 'lacks' mentioned above, I will focus on the assertion of lacking evidence. In this regard, in terms of theoretical and methodological approaches, the sociological interrogations concerning 'absence (https://globalsocialtheory.org/concepts/sociology-of-absences/)' and 'ignorance (https://www.zedbooks.net/shop/book/the-unknowers/)' would be useful; they have critically identified the symbolic meanings of non-existence and non-knowledge (https://www.crcpress.com/The-Social-Life-of-Nothing-Silence-Invisibility-and-Emptiness-in-Tales/Scott/p/book/9781138297975) as well as the socio-political organising and functioning of such. Deconstructing the notion that 'we don't have enough proof' enables us to argue that what 'no evidence' shows is no less than what evidence does.

On the one hand, it is that 'queer trouble' makes a comprehensive survey concerning the health of SGMs almost impossible. Out of the different understandings regarding sexuality and gender between health and social scientists, it is very difficult to define SGM populations across societies. In short, there are too many ways of naming queer people due to their diverse locationalities considering the dominant culture of the place where they live. This conceptual difficulty informs us that, on the one hand, the social determinants of health may be universal, but are context-sensitive as

applied, and on the other, related studies are hardly achievable without generalising the population under research. Even the researchers themselves (https://link.springer.com/book/10.1007/978-0-387-31334-4) would have to acknowledge this partiality in the research process.

It is true that SGM health is far from simply a scientific question, especially if we consider the situations in which SGM members are afraid to see a doctor and face persecution, let alone voluntarily accepting to be *studied*. This has exposed the limits of evidence-based public health when the target populations are hard to define, and even harder to reach in many societies. That is to say, the nexus between the lack of evidence and the lack of definition of queer populations seems inextricable.

Yet, what counts as 'evidence'?

Yet, it would also be irresponsible to simply blame the lack of evidence on 'queer trouble'. The real problem in regard to the underrepresentation of queer communities and the misinterpretation of their health information should be uncovered. Here, I am arguing that, other than the troubling definition of queer people, the intended ignorance – due to non-recognition (omissive) and misrecognition (commissive) of SGM communities and hence non-production of knowledge concerning their health – plays a greater role in reinforcing the social and health injustices against them. That is to ask: What counts as evidence? Could it be that the lack of evidence manifests the evidence of health inequity? Namely, the socially constructed ignorance can be seen as the evidence of health injustice. Therefore, it is important to know how not-knowing functions.

In the absence of knowledge that meets professional standards, we shall consider the knowledge coming from local communities. The selection process of and resource allocation with regard to conducting health research may result in the invisibility of the non-recognised and the misrecognised. For example, a Bangladeshi activist stated at the International Lesbian, Gay, Bisexual, Trans and Intersex Association's Asian Regional Conference (ILGA-Asia) of 2015: 'Health issues of *hijra* are always related to social discrimination. We are often denied access to seeing a doctor.' A Thai transman activist expressed concerns about health professionals' insensitivity: 'Most trans health information is accessible only to transwomen…doctors just don't know what to do with us and our health issues'.[3]

These narratives are rarely documented and used as evidence for health inequity, but they call on us to rethink the absence of evidence in certain places, as reported by the Bangladeshi and Thai governments, for instance. In this light, the tolerance of no-evidence itself could be a form of state-sponsored health inequity. Where there is 'evidence', it can be misrepresented in a biased manner. Indeed, the powerless position of queer people is both the cause and the result of the misinterpretation of health data – mainly by governments and mass media.

Local queer activists are ambivalent about the efforts towards making social injustices against SGMs a health issue, while they have suffered a lot from being over-medicalised subjects (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4918872/). This ambivalence is quite salient in Asian societies. At the 2015 ILGA-Asia Conference, an activist from the Philippines stated that: 'The news about our poor lives attracts audiences for sensational stories', as if 'we are ill for being sexually active and self-indulgent'. And, according to a Nepalese activist: 'The information can be quoted out of context', when people only read that 'international studies say we are less healthy'.

Conclusion: Health is political!

After all, do states really presume that there will be 'enough-ness' of evidence? Can health inequity research be capable of establishing the causation between any social determinant and one's health outcome? If not, what do national delegates mean? Observing the debates in the WHO and

elsewhere, what certain national governments have been doing is to avoid – by not making anything happen – a potential formulation of future international pressure through global health policymaking and its normative discourse.

Through deconstructing the discourse of a 'lack of evidence', we can thus identify the socio-political functions of ignorance and *ignoring*. That is, they did nothing, not because they didn't understand and care. Quite on the contrary, it was because they cared and knew too well that health is always political, and yet, it is not just the politics concerning knowledge production and media representation; it is also international politics.

[1] In my research, I tend to use the term 'SGM' to encompass not only people who identify as lesbian, gay, bisexual and transgender (LGBT) but also those whose sexual practices or gender expressions are considered bad/immoral/abnormal in varied historical and sociocultural contexts. So, SGM and LGBT should not be used interchangeably.

[2] For more information, see the meeting records of the 139th session of EB (http://apps.who.int/gb/ebwha/pdf_files/EB139-PSR/B139_PSR1-en.pdf) in 2016, pp. 3-5.

[3] These are my notes taken at the meetings of the sixth ILGA-Asia Regional Conference, held on 28-30 October 2015 in Taipei.